

Correspondence to: Dr Rita Browne, St Stephens Centre, Chelsea and Westminster Hospital, 369 Fulham Road, London, SW10 9NH, UK; rita.browne@chelwest.nhs.uk

doi: 10.1136/sti.2003.008532

Accepted for publication 27 November 2003

References

- 1 Zeuzem S, Teuber G, Lee JH, *et al*. Risk factors for the transmission of hepatitis C. *J Hepatol* 1996;24(Suppl 2):3-10.
- 2 Filippini P, Coppola N, Scolastico C, *et al*. Does HIV infection favour the sexual transmission of hepatitis C? *Sex Transm Dis* 2001;28(12):725-9.
- 3 Marx M, Murugavel K, Tarwater P, *et al*. Association of hepatitis C virus infection with sexual exposure in southern India. *Clin Infect Dis* 2003;37:514-20.
- 4 Fletcher S. Sexual transmission of hepatitis C and early intervention. *J Assoc Nurses AIDS Care* 2003, Sep-Oct;14(Suppl 5):875-945.
- 5 Matthews-Greer J, Caldito G, Adley S, *et al*. Comparison of hepatitis C viral loads in patients with or without human immunodeficiency virus. *Clin Diagn Lab Immunol* 2001;8(4):690-4.
- 6 Bobik JM, Holodniy M. Impact of highly active antiretroviral therapy and immunologic status on hepatitis C virus quasispecies diversity in human immunodeficiency virus/hepatitis C virus-coinfected patients. *J Virol* 2003;77:1940-50.

Transmission of *Neisseria gonorrhoeae* from a toilet seat

In August 2003 a prepubescent 8 year old girl presented with a sudden onset history of a non-irritating, odourless heavy green vaginal discharge which had developed overnight. She had arrived back in Sydney approximately 24 hours earlier by an international air flight following an overseas holiday with her mother and two adolescent siblings. The family had spent 72 hours in transit flying from Rome to Sydney via Moscow.

The child was taken initially to her family doctor and a heavy growth of *Neisseria gonorrhoeae* was isolated. The organism was resistant to both penicillin and ciprofloxacin. One week later, following an initial course of antibiotics, the child was referred to the author for assessment of possible sexual abuse and ongoing management of the *N gonorrhoeae* infection.

Before boarding a flight to Moscow the family had spent 3 days in a hotel, sightseeing and the previous 2 days with relatives. During the 8 days before arriving in Sydney, the mother had unusually close contact with the child, had shared a bedroom with her, and had accompanied her almost continually. The child's behaviour and demeanour had shown no change and both the child and the siblings were asymptomatic. When questioned by her mother, the child strongly denied any history of genital contact.

The flights to and from Moscow were noted to be full with no spare seats. Both the mother and the child stated that there were queues to use the toilets during both flights and that by the end of the flights the "toilets were very dirty."

The mother stated that when the child used a public toilet the child always wiped the seat with toilet paper before using it. The child confirmed this. She said her fingers occasionally became dirty while wiping the seat.

Genital examination of the child revealed no significant redness of the introitus or physical abnormality. She had an intact annular hymen; however, the absence of

genital injury has no relevance in making a diagnosis that excludes sexual abuse.¹

As part of the routine investigation, the matter was reported the New South Wales Department of Community Services and all family members were tested for *N gonorrhoeae* and were negative.

It is important that all cases of *N gonorrhoeae* in children be fully investigated for sexual abuse, and reported to the relevant child protection authorities. There is no doubt that almost all gonococcal vaginal infections in prepubertal children are sexually transmitted,² and this may include those previously reported as non-sexual.³ However it is also accepted that cases of non-sexual transmission of *N gonorrhoeae* in children do occur,⁴ but proof beyond all doubt can be very difficult to document scientifically.

On the basis of the demeanour of the child, reports of increasing rates of gonorrhoea in the former Soviet Block countries,⁵ the incubation period for symptomatic *N gonorrhoea*, the history from the mother and her unusually close supervision of the child, as well as the child's known behaviour in public toilets, it is the belief of the author that the child most probably contracted the infection via autoinoculation while using a mixed toilet in a crowded aeroplane.

L Dayan

Sexual Health Services, Northern Sydney Health, Clinic 16; Block 3, Royal North Shore Hospital, Pacific Highway, St Leonards; Sydney, Australia 2065; ldayan@doh.health.nsw.gov.au

doi: 10.1136/sti.2003.008714

Accepted for publication 5 December 2003

References

- 1 Heger A, Ticson L, Velasquez O, *et al*. Children referred for possible sexual abuse: medical findings in 2384 children. *Child Abuse Negl* 2002;26:645-59.
- 2 Hammerschlag M. Sexually transmitted diseases in sexually abused children: medical and legal implications. *Sex Transm Infect* 1998;74:167-74.
- 3 Potterat JJ, Markewich GS, Rothenberg R. Prepubertal Infections with *Neisseria gonorrhoeae*: clinical and epidemiological significance. *Sex Transm Infect* 1978;5:1-3.
- 4 Lipsitt HJ, Parmet AJ. Nonsexual transmission of gonorrhoea to a child. (Letter) *N Engl J Med* 1984;311:470.
- 5 Borisenko KK, Tichonova LI, Renton AM. Syphilis and other sexually transmitted infections in the Russian Federation. *Int J STD AIDS* 1999;10:665-8.

Detection of *Chlamydia trachomatis* by polymerase chain reaction in male patients with non-gonococcal urethritis attending an STD clinic

Genital infection with *Chlamydia trachomatis* (35-50%) is the single most identifiable cause of non-gonococcal urethritis (NGU) in heterosexual men and may have serious consequences, not only for men but for their partners. In India, a high prevalence of genital *C trachomatis* infection has been reported in women.¹ However, there is considerably less information on male chlamydial infection.^{2,3} There is a definite need for reliable screening of *C trachomatis* genital infection in men in order to prevent under-diagnosis of genital chlamydial infection and to facilitate better clinical management of this infection in India. This study was

undertaken with the aim to find the prevalence of *C trachomatis* infection in male patients with NGU attending the STD clinic of a major city hospital in north India.

After obtaining informed consent, 90 male patients (age 18-55 years) clinically suspected to have urethritis and attending the STD clinic at Safdarjang Hospital, New Delhi were enrolled. Of these, 85 NGU patients were included in the study on the basis of microscopic examination of urethral swab specimens for the presence of >10 polymorphonuclear neutrophils/high power field and negative results for *Neisseria gonorrhoeae*. None of the patients showed genital lesions. The patients belonged to various socioeconomic groups and the majority of them admitted to having extramarital heterosexual contact. The specimens were collected using sterile cotton tipped swabs (Hi Media, Mumbai, India) from the urethra of each patient after removing the secretions/discharge. The samples were collected in vials containing phosphate buffered saline for screening by a plasmid specific polymerase chain reaction (PCR) assay (517 bp)⁴ and confirmation by culture in McCoy cell line followed by direct fluorescent assay (DFA) (Microtitre, Syva Corporation, Palo Alto, CA, USA) on infected coverslips.⁴

Urethral *C trachomatis* infection was found by PCR (fig 1) and culture in 20 (22.3%) and 21 (24.7%) symptomatic male NGU patients, respectively. Further, chlamydial infection was most common (27.6%; statistically non-significant) in men in the 26-35 years age group. In an earlier hospital based study on male NGU patients reported from India, *C trachomatis* and *Trichomonas vaginalis* were the most common pathogens found by culture in urethral discharge specimens, being responsible for 18% and 19% cases, respectively.² Another study from Chennai, India reported the prevalence of *C trachomatis* infection in male and female genital swab specimens as 18.9% and 32.2% by culture and PCR, respectively.³ *Chlamydia* and *Ureaplasma urealyticum* were the most common infecting and co-infecting pathogens (51.5% by PCR in first void urine and 45.6% by culture in intra-urethral swab specimens, respectively) in male patients with NGU attending an Israeli STD clinic.⁵ In a study from Turkey, the prevalence of *C trachomatis* and *N gonorrhoeae* (screened by ligase chain reaction in either

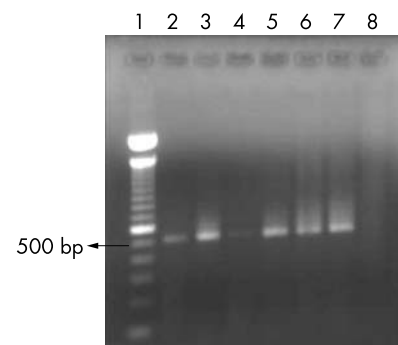


Figure 1 Detection of *Chlamydia trachomatis* by polymerase chain reaction in 1% agarose gel electrophoresis using 517 bp plasmid primer. Lane 1 is DNA marker. Lanes 2-6 show amplification of *C trachomatis*. Lane 8 is a negative control. Lane 7 is a positive control for *C trachomatis*.

urethral swabs or first void urine) among men with symptomatic urethritis was 15.7% and 9.4%, respectively.⁶ This should be viewed with concern particularly in developing countries like India where screening for *C trachomatis* is not done on a routine basis and, hence, extensive screening should be conducted for detection of genital *C trachomatis* infection in men using sensitive and specific molecular assays like PCR.

V Vats, S Rastogi, A Kumar, M Ahmed, V Singh, A Mittal

Institute of Pathology (ICMR), Safdarjung Hospital Campus, Post Box no 4909, New Delhi 110 029, India

R K Jain, J Singh

Department of Sexually Transmitted Diseases (STD), Safdarjung Hospital, New Delhi 110 029, India

Correspondence to: Dr Aruna Mittal, Institute of Pathology (ICMR), Safdarjung hospital campus, Post Box no 4909, New Delhi, 110 029, India; amittal_iop@yahoo.com

doi: 10.1136/sti.2003.008839

Accepted for publication 30 January 2004

References

- 1 Singh V, Rastogi S, Garg S, et al. Polymerase chain reaction for detection of endocervical Chlamydia trachomatis infection in Indian women attending gynaecology outpatient department. *Acta Cytol* 2002;**46**:540-4.
- 2 Bhujwala KA, Seth P, Gupta A, et al. Non-gonococcal urethritis in males: a preliminary study. *Ind J Med Res* 1982;**75**:485-8.
- 3 George JA, Panchatcharam TS, Paramasivam R, et al. Evaluation of diagnostic efficacy of PCR methods for Chlamydia trachomatis infection in genital and urine specimens of symptomatic men and women in India. *Jpn J Infect Dis* 2003;**56**:88-92.
- 4 Mittal A, Kapur S, Gupta S. Chlamydial cervicitis: role of culture, enzyme immunoassay and Giemsa cytology in diagnosis. *APMIS* 1993;**101**:37-40.
- 5 Srugo I, Steinberg J, Madeb R, et al. Agents of non-gonococcal urethritis in males attending an Israeli clinic for sexually transmitted diseases. *Isr Med Assoc J* 2003;**5**:24-7.
- 6 Agacfidan A, Moncada J, Aydin D, et al. Prevalence of Chlamydia trachomatis and Neisseria gonorrhoeae in Turkey among men with urethritis. *Sex Transm Dis* 2001;**28**:630-2.

BOOK REVIEW

Letting Them Die—Why HIV/AIDs prevention programmes fail

By Catherine Campbell. Pp 214; £40.00 (cloth) £12.95 (paper). Oxford: James Currey, September 2003. ISBN 0-85255-867-8 and 0-85255-868-6.

What is going on with HIV in South Africa? The epidemic escalates with no sign of

slowing down, making the country the worst affected in the world. The government continues to try and find excuses not to deliver either treatment or prevention programmes. The sense of stigma is so palpable that ignorance of serostatus carried to the grave seems to be the usual way of living with the virus.

This book tells the story of an HIV intervention project in Carletonville, a mining area near Johannesburg, where mineworkers and female sex workers eke out a day to day existence in which overindulgence in alcohol and unprotected sex appear to be the norm. It tells a salutary tale of a project conceived optimistically that gets dragged down through petty arguments, jealousy, and mistrust but still emerges to provide fresh insights into how to tackle the epidemic.

Working in HIV in South Africa has always been full of challenges and, based on the story told here, those challenges would appear to be increasing. The author (a social scientist and member of the project research team) reports not only the successes, but also, more bravely, the failures of the project. She sets out her stall to tackle HIV through a project focusing at the community level. The plan was to have a project directed by stakeholders who would work together as a group and develop guiding principles that local HIV affected communities could use to support both individuals and promote HIV prevention programmes among female sex workers, miners, and youth. Unfortunately, the mine groups didn't cooperate and other individuals saw themselves as just that, individuals rather than members of a cohesive, homogeneous community. Peer education, a major component of the project, faced many difficulties. With the benefit of hindsight, it seems as though many of the important stakeholders did not perceive adequate ownership of the project and became disillusioned early on leaving most of the day to day running to those employed by the project directly.

The book is well written and clear and is recommended reading for anyone contemplating a large scale HIV prevention project, whether as a planner, implementer, or evaluator. The book explains social science terminology succinctly for those with limited knowledge of the discipline. It also demonstrates and describes very well that what works in one part of Africa will not necessarily work elsewhere, and that initial local assessment at the design stage of a large scale project is paramount.

As HIV continues to spread outside the high risk groups, the need to educate at the community level also increases but the former group should not be forgotten. A combination of both strategies is probably the best approach. The reality is that, although the HIV epidemic in South and southern Africa has come a long way, there is still some distance to go. Hopefully, those involved in HIV project management will

pick up the lessons set out in this excellent little book.

N O'Farrell

Pasteur Suite, Ealing Hospital, London UB1 3HW, UK; ofarrell@postmaster.co.uk

CORRECTION

doi: 10.1136/sti.2003.006957corr1

The reference list of the paper by V J Johnston, H Britt, Y Pan, and A Mindel, entitled "The management of sexually transmitted infections by Australian general practitioners" (*Sex Transm Infect* 2004;**80**:212-5), was published incorrectly. The correct reference list can be found as a data supplement to the article online at <http://www.stijournal.com/cgi/content/full/80/3/212/DC1>.

NOTICES

22nd International Papillomavirus Conference and Clinical Workshop

This will be held 29 April to 6 May 2005 in Vancouver, British Columbia, Canada. Topics will include animal papillomaviruses, diagnosis, epidemiology, HPV associated neoplasia in the developing world, immunology, molecular pathogenesis, natural history, screening, transcription, and treatment.

For more information please contact: 22nd IPC Secretariat, C/o Venue West Conference Services Ltd, #645-375 Water Street, Vancouver, BC V6B 5C6, Canada; tel: +1 604 681 5226; fax: +1 604 681 2503; email: congress@venuewest.com; website: www.hpv2005.org.

16th Biennial Meeting of the ISSTD

The 16th Biennial Meeting of the International Society for Sexually Transmitted Diseases Research (ISSTD) will be held 10-13 July 2005 in Amsterdam, The Netherlands. The meeting will be organised jointly by Dutch and Belgian STD researchers. For more information please visit www.isstdr.org.

Answers to MCQs on p 320

- (1) a
- (2) c
- (3) b
- (4) c
- (5) c
- (6) d
- (7) d
- (8) a
- (9) d
- (10) b